

# Prior Authorization Request Form

To submit requests, please fax completed form to the Utilization Review Department: 202-905-0157.  
 If you have any questions, you can reach the Utilization Review Department directly: 202-821-1132.

Providers are responsible to obtain prior authorization for services prior to scheduling. Please submit clinical information as needed to support medical necessity of the request. Prior authorization payment is subject to request meeting medical necessity

Requests may not be processed if clinical information or CPT and ICD-10 codes are missing. As a reminder, authorization is not a guarantee of payment; payment is subject to benefit coverage rules, including enrollee eligibility and any contractual limitations in effect at the time of service. Please select urgent only when the enrollee's life or health may be seriously jeopardized. Doing so will help us to respond to your request accurately and with greater efficiency.

Today's Date: \_\_\_\_\_ Requested Date of Service: \_\_\_\_\_

REQUEST TYPE		
<input type="radio"/>	Urgent Preservice	Decisions will be made within 24 hours of receipt; I certify that applying the standard review time frame may seriously jeopardize the life or health of the enrollee. (Enrollee has an appointment or requires service within 24 hours, today, or is in the office now.)
<input type="radio"/>	Urgent Expedited Pre-service	Decisions will be made within 72 hours of receipt of the request. (Enrollee will need services within 72 hours.)
<input type="radio"/>	Standard Non-Urgent Preservice	Decisions will be made no later than 14 calendar days of receipt of request. (Enrollee will need services within the next 14-days or more). *Most requests fall in this category. *
<input type="radio"/>	Post-Service	Decisions will be made no later than 14 calendar days of receipt of request. (Enrollee received services already, authorization was not given, and a claim was not submitted or denied.)

Physician's Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

MEMBER INFORMATION		
Alliance/Medicaid ID Number:	Enrollee Last Name:	Enrollee First Name:

Date of Birth:   /  /   Gender:  Male  Female  
 Additional Insurance carrier  Yes  No Insurance Carrier Name: \_\_\_\_\_

REVIEW TYPE			
<input type="radio"/> Initial	<input type="radio"/> *Change DOS/Setting	<input type="radio"/> *Extension of Services	<input type="radio"/> Additional Clinical
<input type="radio"/> Cancel	<input type="radio"/> *Other (specify)	<input type="radio"/> Discharge Planning (Services needed for member discharged from inpatient setting such as hospital, skilled nursing facility, subacute facility, etc.)	

\*Please Specify (If applicable, previous authorization number) \_\_\_\_\_

SERVICE TYPE:				
<input type="radio"/> Orthotics/ Prosthetic	<input type="radio"/> Home Care	<input type="radio"/> Non-Par	<input type="radio"/> Durable Medical Equipment (DME)	<input type="radio"/> *Other

\*Please Specify (If applicable, previous authorization number) \_\_\_\_\_

PROVIDER INFORMATION		
Submitting Provider Name:	Contact Name and Phone Number:	Fax Number:
Services Provided by or Facility/Provider ID#	Contact Name and Phone Number:	Fax Number:

TREATMENT SETTING:				
<input type="radio"/> Outpatient	<input type="radio"/> Inpatient	<input type="radio"/> Home	<input type="radio"/> In-Office	<input type="radio"/> * Other

\*Please specify if other selected: \_\_\_\_\_  
 DONOT WRITE BELOW THIS LINE: FIELDS TO BE COMPLETED BY CAREFIRST CHPDC

Authorization # \_\_\_\_\_ Date of Service Coverage Period \_\_\_\_\_

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Enrollee ID#: \_\_\_\_\_

HCPCS/CPT CODES				
ICD-10 Code	HCPCS/CPT	Code Description	Dates of Service	
			From	Thru
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I
			I I	I I

Other Clinical Information- Include/attach clinical/office notes, labs, imaging reports, etc.to support medical necessity.  
**If this is an out-of-network request, please provide an explanation.**

**Number of Visits Being Requested:** \_\_\_\_\_

**REHABILITATION SERVICES**

**Type of Therapy:**       Speech       Physical       Occupational       \*Other

Number of Units/Visits Requested:	Previous Authorization Number:	Date(s) Requested:
<input type="radio"/> Extension	<input type="radio"/> Initial	

Additional Comments:

**CareFirst CHPDC**  
 1100 New Jersey Avenue, S.E.,  
 Suite 840, Washington, DC 20003

**Utilization Management Contact Information**  
**Phone: 202-821- 1132**  
**Fax: 202-905-0157**

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Enrollee ID#: \_\_\_\_\_

HOME CARE		
Name of Agency	Number of Units/ Visits Requested:	Number of Previous Visits:
Previous Authorization Number:	<input type="radio"/> Initial	<input type="radio"/> Extension

Additional Comments:

DURABLE MEDICAL EQUIPMENT		
Diagnostic Indication:	Duration and Frequency of Use:	Acute or Chronic condition:
Previous Authorization Number:	Length of time needed:	
<input type="radio"/> Initial	<input type="radio"/> Renewal	
<input type="radio"/> Rental	<input type="radio"/> Purchase	

Additional Comments:

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**Fax: 202-905-0157**